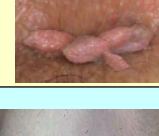


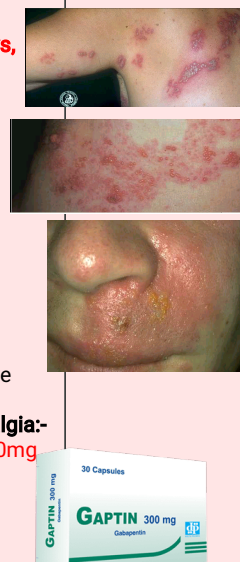
	Def. & cause	Clinical picture	Diagnosis & D.d	Treatment	Notes
Superficial pustular folliculitis (Ostiofolliculitis) التهاب جيبات الشعر	very superficial Acute infection of the ostium of hair follicle Staph. aureus (MC Cause)	1ry = pustules Site = in <u>follicular</u> distribution often associated with hairs. - children ~ <u>scalp</u> (M.C site) - adults , other frequent sites include (the <u>neck, face and axillae</u>). -Also develop secondarily in scratch/insect bite.	G-ve folliculitis (in acne pt. ē long term ABs) Pseudomonas Folliculitis	- Topical:(most cases) Antiseptic- (gentian blue/ K permanganate) Antibiotec -(Erythromycine) - Systemic(severe case) -Eryth- Tetra- ttt. Pediculosis if present.	
Sycosis vulgaris (S.Barbae) قوباء الدفن barber's itch	perifollicular, chronic , pustular infection of bearded area staphylococcal infection of the bearded region	1ry :- inflammatory papules 2ry :- pustules, crust and a tendency to recurrence. (begins with erythema and burning or itching .) Site :- bearded area (<u>upper lip near the nose usually.</u>) - rupture after shaving or washing ~ leave an erythematous spot. - With the formation of pus about the hairs they become loose and can be readily epilated	Tinea barbae (painless removal of hair) Acne vulgaris , (hypersecretion of sebum, different localization, 1ry comedones) Pseudofolliculitis barbae . (chronic inflammation, الشعره تدخل داخل الجلد) Seborrheic dermatitis (mild type in NL fold, +dandruff)	- Antiseptic(- Antibiotic local	 
Impetigo Contagiosa القوباء المعدية	A superficial cutaneous infection of epidermis. commoner in children. (Φ commonest infect. In children) caused by:- Streptococci group A. or staphylococci aureus (Φ m.c In developed Countries) Strept. May complicate by acute glomerulonephritis. Strept.	1ry: vesicles (discrete, thin-walled that rapidly become pustular and then rupture). (rarely pt. Come in vesicle stage) 2ry:- crusts (yellow brown honey colored & sticky & thick) can usually be removed readily, leaving a smooth, red surface Site : the <u>face (perioral area)</u> , <u>hands, neck</u> and <u>extremities</u> . Φ strept. Infection ➔ May ass. ē fever, L.adenopathy, (But not serious) no risk of Rheumatic fever	Face : -herpes simplex. -Eczema -fungal infection Trunk ~ prurigo simplex acute (papular urticaria) VZV SSSS.	Non complicated case (no fever/high WBCs/no L.adenopathy) :- start with Topical ABs. Complicated /no response to topical ABs :- give systemic ABs - antiseptic	 
Bullous Impetigo القوباء ال	A superficial cutaneous infection. Mostly on neonate (kidney can't destruct toxin of staph.) Etiology: Staphylococcus aureus only (phage 2 type 71)	1ry:- Bulla (clear yellow turbid) 2ry:- crust Site : on the face But may appear anywhere (trunk @)	Epidermolysis bullosa (respond to steroid not AB كثير في الاسر الى . تكثر من زواج الأقارب bullous pemphigoid (old pt. Pemphigus violaceous (superficial p.) P. Vulgaris SSSS - TEN Crusted multiple lesion d.d= PRP ,PR ,Psoriasis	As impetigo contagiosa but usually need systemic Systemic antibiotic: Erythromycin , cephalixin, penicillin. (©CoAmoxiclav) Topical antibiotic: Neomycin, Bactroban (©fucidic acid®) - antiseptic.	 

VISIT...

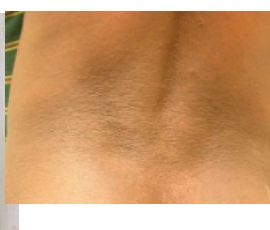
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Erysipelas الرياح الحمراء	- characteristic type of superficial cellulitis of the skin with <i>superficial lymphatic vessels</i>. Cause:- beta-hemolytic Strept., rarely staph. aureus. - Pathogenesis: the presence of <u>minimal trauma or abrasion</u>. <i>(T.pedis interdigitalis)</i>	a bright red, brown, oedematous(well defined@) area, in severe cases ,the epidermis may become <u>bullous, pustular or necrotic</u>. Site:- face (Female), lower leg(male) or arm. (unilateral&hot). malaise ,fever and headache. May complicate by ulcer (resistant to ttt.) ΦNote:- Erysipeloid (well demarcated, violaceous, cellutic plaque (<i>éout. epidermal changes of scale or vesiculation</i>), following cleaning fish;	Face= -Herpes zoster if bollus contact dermatitis. -cellulitis photo/photop hyto Dermatitis. sarcoidosis. cellulitis discoid LE(in check ,but long time) . Lower limb= cellulites , erythema nodosum (but 1ry nodular lesion,bilat,pain) E. Induratum(type of TB ,nodular) Erysipeloid	Systemic: Antibiotics <i>penicillins</i>-(1st line) - <i>erythromycin</i>-(if allergic to penicillin) . "Dr. Give erythromycin(upto 6g) 1st. & if no improvement/pt. in hospital give penicillin (inj. 8-24Million unit/day)" Tetracycline +topical: Antibiotic oinment +Antiseptic for fissuring /trauma site. +analgesic +antipyrctic. +ttt. T.pedis if present. Untreated erysipelas can be fatal due to vascular thrombosis ,bactermia ,or toxin release. (complications)	
Paronychia التهاب جانب الضفر	Inflammation or infection of the nail fold. <u>Acute paronychia</u> staphylococcus aureus. (most pt.- women) <u>Chronic - C.albicans</u> (mostly in Children -ass. e oral candidiasis)	erythema and very painful swelling of the lateral or proximal nail fold. with abscess formation	diagnosis Scrabing &KOH exam :- staph~no change. candida ≈Yeast DD. -Psoriasis - L.planus. -Atopic dermatitis CD.	Antiseptic Nystagram (antibiotics, antifungal ,steroid) Surgical removal of pus	
Intertrigo التسلخات	superficial Inflammatory dermatitis. (not infectious) Φ(note there is infectious types of intertrigo as candidal intertrigo,Bacterial intertrigo Predisposing factors : - <u>excessive sweating/hyperhidrosis.</u> - <u>obesity.</u> - <u>diabetes mellitus</u>	Lesion :- erythamatus ,macerated and secondarily infected (bacterial or fungal) intertriginous area ,due to friction , heat ,moisture ± erosions , fissures and exudation burning and itching. Localization: intertriginous areas (neck , axillae , Antecubital areas , finger webs ,inframammary area, Inguinal , perianal, intergluteal areas and toe webs.)	DD: Eczema - Psoriasis. Inversus. Hailey-Hailey disease.(Benign familial pemphigus) erythrasma. Severe seborrheic Dermatitis. Φatopic D. Fingerwebs. C.albicans ,contact dermatitis On toeweb - tenia pedis interdigitalis	TT:▪ antiseptic- ▪ antibiotic topical. ▪ antifungal topical Can give Nystagram Avoid steroid (atrophy in intertrigenous area)!! Moist dressing , zink oxide oinment (decrease friction,prevent faces,urine inflammation in intergluteal type) Wt. Reduction	
Erythrasma الولج	Is a chronic superficial infection of the intertriginous areas of the skin. corynebacterium minutissimum. Predisposing factors : - excessive sweating/hyperhidrosis. - obesity - diabetes mellitus	Lesion :- Reddish-brown , (Φsharply marginated patches.) Slightly scaling patches occurring in the intertriginous areas.	Diagnosis. Wood,s Light ~coral-red أحمر مرجاني fluorescence. (D. to porphyrin). Skin scrub to rull out fungal infection DD: cutaneous Candidiasis -cont- derm- -Tinea cruris. -Ps. Inversus. - porphyria cutanea tarda -Ichthyosis nigricans	TT: Systemic : Erythromycin 4x250mgx7Days Topical : Erythromycin or clindamycin. Φbenzoylperoxide 2.5%gel daily after shower Fitz. Topical preferable ,twise for 7Days.	

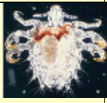
VIRAL INFECTION					
	ETIOLOGY	CLINICAL PICTURES	DIAGNOSIS & DIFFERENTIAL DX.	TREATMENT	IMAGES
Warts. الآثليل 1-V.vulgaris. 2-plane W. 3-plantar W. 4-genital W.	Def. <i>intraepidermal</i> lesions caused by the a range of DNA viruses human papilloma viruses (HPV).	The virus grows within the stratum corneum never migrating below the granular layer They can occur at any age but are most common in children and young adult transmitted by direct contact	-verruca vulgaris easy dx. Plane more d.dx Plantar	1- electrocoagulation (cautery) 2-cryotherapy with liquid nitrogen. 3- curettage. 4- salicylic acid. &/ lactic acid 5- 5% formalin lotion	
1- verrucae vulgaris: (Common warts) الآثليل الشائعة @Incubation P.=1-8m. Note:- (filiform wart is subtype of V. Vulgaris)	HPV type 2 - Eyelids: long, <i>filiform</i> المبردي warts are. most common (d.d ē skin tags) - Beard area and Scalp: Both flat and filiform warts	1ry:- papules (Violaceous, elevated rounded, rough papules. (Φ hyperkeratotic, clefted surface, with vegetations) Site:- the hands "@dorsum" (fingers and palms), periungual (difficult to ttt.) eyelid , bearded area and scalp . size- pinpoint to more than 1 cm. slowly growing in size (week to months) May be transmitted by inoculation/contact. (لهذا قد يحصل) kissing warts → إنه لو أصيب أصعب تصاب الي ملاصق لها	Fitz. ▪ palm&sole :- single-callus, corn , epidermal inclusion cyst. Multiple:- Palmoplantar keratoderma, Psoriasis , Secondary syphilis. ▪ Dorsum of hand/feet:- single SCC Keratoacanthoma TB verrucosa cutis. multiple plane W. Actinic keratosis	practically = 1 Electrocoagulation (cautery) after local anesthesia is the best . Cryotherapy (difficult in our country, -185.8° & restricted for:- BCC, SCC, Keratoacanthoma, pemphigoid. Not for face. salicylic acid collomack® - not preferred on face (hyperpigmentation)	 
2- Plane warts (Flat wart) الآثليل المسطحة	HPV type 3 less often types 10, 27 and 41	1ry :- papules (Flat surface, skin coloured or grayish-yellow, slightly hyperpigmented found on the face . Size- 2-4mm flat papules. Site: face , (mostly forehead may reach scalp) neck, hands, arms, trunk. <i>Kobner phenomena (dr. adel)</i>	Acne vulgaris (white head) forehead. L.planus perioral D. Folliculitis. Seborrheic D. Skin tags. Impetigo. HSV (but 1ry:- grouped vesicles) fitz. Hand -- +L.planus. trunk, extremities -- +P.V	▪ Spot pin (not cautery - it need large lesion) ▪ Or Small sized cautery. ▪ Salicylate acid "collomack®"	 
3- Plantar wart آثليل أخمص القدم - الأخمصية	HPV type 1 and less commonly, 2, 4	painful ē pressure , rounded, elevated, hyperkeratotic lesions. Site:- on plantar surface. (Φ Pressure points, heads of metatarsal, heels, toes.)	Tenia pedis hyperkeratosis Callosity! (heal fissure) not elevated مسمار القدم (عين السمكة) @callus (creases present), psoriasis. PRP. Hyperkeratosis palmoplantar	Cautery (electrocoagulation)	
4- genital warts (condylomata acuminata):	HPV type 6 and 11 <i>sexually transmitted</i>	Lesion Φ epidermal and dermal papules or nodules, variable size, Localization: glans penis, perianal, vulvovaginal area and mucous membrane.	▪ G.penis : Condylomata lata (secondary syphilis) ▪ M.M = candida albicans, behçet, L.planus, pemphigoid, DL. aphus painful not elevated	Salicylate acid ??? @Φ As verruca vulgaris. + Podophylline 25% (contra. for pregnant) Φ Prevention, vaccine	 
Molluscum contagiosum المثبيات المعدية @I.P -upto 9 months.	infectious cutaneous lesion caused by a pox virus . Highly contagious. More in children, sexually active adults and genital skin and ! HIV.	Lesion :- elevated, smooth, reddish (umbilicated, shinney) papules (have a small central depression) site :- on face, neck, trunk and genitalia. (Φ Koebner phenomena) 10-30% of patients with AIDS have Molluscum Contagiosum	Chickenpox Hsv Prurigo simplex acut Φ verrucae	▪ Cryotherapy. or curettage ▪ Salicylate acid - in genitalia, trunk (not face) Φ topical cantharidin	  

	ETIOLOGY	CLINICAL PICTURE	DIAGNOSIS SDD.	TREATMENT	IMAGES
Herpes simplex (الحلأ البسيط)	Cutaneous infection due to herpes virus hominis (HVH) two antigenic types: - type I is responsible for the common herpetic infection of the face and oropharynx - Type II herpes simplex infects the genitalia & spread by skin to skin contact, usually during sexual activity.	active primary HVH 1 infection: febrile child with painful ulcerated mouth and painful enlarged local lymph nodes. +lesion :- (persist for 3-6 days) . group of small blisters on the skin surface. on buccal MM. (herpetic gingivostomatitis) (@very painful multiple ulcer, no crust). trunk (may linear distribution confused with HZ..) @herpetic whitlow -in finger (children, dentist,) Recurrent Herpes simplex :- lesion commonly (outer 1/3 of lower lips) Predisposed by: 1-fever 2-trauma 3-menstruation 4- stress. 5- immunodeficiency state genital herpes~ grouped vesicles after time become hyperpigmented. Φ1ry multiple stages, extensive disease	DD. On tongue:- (painful) candidiasis (painless+hx. Of excessive AB.) L.planus (reticular usually) Behçet disease. aphthous ulcer (Not preceded by vesicles, only on mucosa) aphtha vulgaris. Φ Genital Herpes:- Chancroid (Deep ulceration with exudate.) Syphilis (Painless, not preceded by vesicles.) Lymphogranuloma venereum (Painless ulcer, unimpressive primary lesions) Granuloma inguinale (Painless ulcer, exuberant lesions)	- Topical: Antiseptic:- in G.stomatitis. (gargle فم غسول فم hydrogen peroxide) gentian violet (skin) Acyclovir cream. 5-6 time per day .viramid® - Syst:- (...day) Acyclovir 200mg tab 5-6 tab per day	
Chicken pox (varicella) جدري الماء	It's primary infection with Varicella - Zoster Virus (VZV) 90% of cases occur in children < 10 years. incubation period :- 10 to 21 days . Transmission by direct contact with the lesions initial viral replication in the nasopharynx and conjunctiva	Prodrome •Characteristically absent or mild. Esp. In children 1ry:- (Φpruritic) vesicles ,(vesicles ,papules on Erythematous base. 2ry:-The vesicles quickly become pustular, impetigo, crusted (all evolution stages may noted simultaneously=polymorphic Localization: on the face, trunk and on the M.M. (Φpalm & sole spared) +general symptoms FAHM (usually in children) Complication more in adult. (CHILD selflimiting usually) 2ry bacterial infection ê staph. aureus or a strept. is M.C complication of varicella. osteomyelitis.rare. pneumonia is uncommon in normal children but common in adult. (by bacterial /by Varicella, + a difficult Dif-Diag) Cerebellar ataxia and encephalitis are the most common neurologic complications..	prurigo simplex acut (strophulus) Smallpox (all lesions are in the same stage), disseminated HSV infection, - secondary syphilis. bullous impetigo -تنصح المريض لا يهرشها ولا يقشره او بتترك أثر ممکن يغتسل پس بدون صابون بلیفة خشنه وما یفحس	Uncomplicated cases: Antiseptic -for ruptured vesicle to prevent scar. acyclovir cream and tab- (if severe) 20mg/kg - for pruritis antihistamine. & soothing agent (calamine lotion) Complicated case (usually adult) :- Emergency ttt. (need admision) and ttt. Of complication As Antibiotics for 2ry bact. Infection , others..	
Herpes zoster:	reactivation of dormant HZV) chicken pox virus= varicellae zoster V. Disease of adult life and old age , very rare in children (now not rare) and healthy young adults.	prodromal of:- severe pain , usually in a dermatome distribution ,malaise ,and sometimes fever. Lesion (unilateral) :- a linear erythematous band develops on this dermatome distribution Then Groups of small blisters (grouped vesicles) develop on the erythema . Some blisters crusted may secondarily infected. + local lymphadenopathy is common. Localization: On the face : H. Z ophthalmic: the ophthalmic division of the fifth cranial nerve is involved. Ear : Otic Zoster (Ramsey-Hunt Syndrome): by involvement of the facial and auditory nerves by the varicella zoster viruse. (Tiny erosion may seen on tympanic membrane or along the ear canal.) On the Trunk:- lesion extend to back (it may dessiminate to genitalia (difficult ttt.&cosmotic_disfiguring)	Face= PHOTO/PHOTOPHYTODERMATITI s Tinea Barbe. ACD. nevus flammeus erysipelas (hot, tender) bullous impetigo Φ Prodromal Stage/Localized Pain (can mimic migraine, cardiac or pleural disease, an acute abdomen, or vertebral disease.) - Post herpetic neuralgia :- may persist for variable time depend on site as (1y in eye & ear /2y if genitalia.) Or depend on age (in old for years „in young for months)	Systemic - Antiviral - Acyclovir 800mg 5X /day 7 days, analgesic :- panadol, NSAID. GABAPENTIN (good result) Topical. Acyclovir cream. Antiseptic - Cosolution for ophthalmologist. - Prednisolone local eye /systemic. Post herpetic neuralgia:- Gabapentin (gabtin 300mg tab) 1x1 for 2month. . الإبر الصينية physiotherapy	

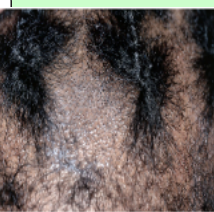
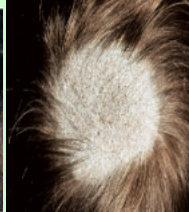
Acute papular onchodermatitis||| Chronic papular onchodermatitis||Onchocercal atrophy. |||Onchocercal depigmentation ("leopard skin")|



Onchocercal nodule

	Etiology & life cycle	Clinical picture	Diagnosis and treatment	Images
Head lice (الكنم) (M.C type)	<i>pediculosis capitis.</i> all levels of society and ethnic groups. (common in children ,bad hygein) MOT:- head-to-head contact Φ Hair grow 0.5m/day (1.5cm/month) so if nits on hair 15cm from scalp ≈ infestation 9months	▪ Clinical :- sight of children scratching their heads(pruritis) sight of head lice /multiple hair nits on hairs of scalp ▪ Diagnosis:- clinically. plucking the hairs studied microscopically⇒ nits from seborrheic scales Wood's light ⇒ white fluorescence reflection.	Φ DD. ▪ nits- dandruff Black/white pidera. ▪ scalp pruritis impetigo L.P chronicum Treatment ▪ Specific Agents:- (1)synthetic pyrethroid (Permethrin 1% cream rinse/lotion(NIX® OTC drug). Half an hour then wash. A second treatment 7 to 10 days after. 2) Synergized (natural) pyrethrins ▪ Nits should be removed with the fine-toothed comb.	 FIGURE 28-11 Pediculosis capitis: multiple nits on scalp hair. A. Arrows, grayish white egg capsules (nits) are firmly attached to the hair shafts, visualized with a lens. On close examination, these have a bottle shape. B. Under a microscope, an egg with a
2) Pubic (Crab) Lice	<i>Phthirus pubis</i>  MOT:- sexually, frequently coexisting with other sexually transmitted diseases.	▪ Clinical Manifestations:- site in:-the pubis ,may thighs, trunk, perianal area,@ eyebrow ▪ Diagnosis:- numerous nits cemented to the pubic or perianal hair. ova grow out with the hair, (as in pediculosis capitis),	▪ DD. trichomycosis pubis white pedra, pruritic dermatosis atopic D. seborrheic D. T.cruis folliculitis scabies M. Contagiosum) ▪ Treatment of pediculosis Pubis. Pyrethrins! (safe & effective) applied to infested and adjacent hairy areas.) Sexual contacts ⇒ treated simultaneously. Fitz.(Screen for concomitant STDs& ttt. It.)	
3)Body Lice-	<i>Pediculosis humanus</i> ▪Crowded conditions. ▪contaminated clothing or bedding. ▪homeless population	Clinical Manifestations:- macules or papules with numerous vertical excoriations caused by intense itching.	DD. -pruritic dermatosis..... scabies , -Treatment :- ▪ permethrin 5% cream (2.5%for children) ▪ proper hygiene, bathing, use of clean clothing and bedding, ▪ proper nutrition.	
Cutaneous Larva Migrants البقعة المهاجرة Creeping/sandworm eruption	Etiology:- <i>Ancylostoma braziliense</i> (M.C. cause.) ▪ Larvae of hookworms (nematodes) of dogs, cats and other mammals Life Cycle:- -human (dead-end host) acquires the parasite from an environment contaminated with animal feces. Third-stage larvae penetrate human skin ⇒ migrate (up to several centimeters a day,) usually between the stratum germinativum and stratum corneum.	▪ Clinical Features Lesion:- single or multiple Erythematous, raised and vesicular, serpentine ~ may linear approximately 3 mm wide and may reach 15 to 20 cm in length. intensely pruritic / painful. Site:- feet, buttocks, and genitalia @hand	Treatment ▪ topical :- thiabendazole, ivermectin or albendazole. ▪ systemic thiabendazole(fitz. 50mg/kg in 2divided dose for 2-5days) ▪ Cryotherapy for advancing end of larva migrans. Fitz.(Don't attempt to extract parasite ,it's not in visible site)	 
Dracunculiasis	Dracunculiasis ((Dracunculosis, Guinea worm disease, Medina worm)) <i>Dracunculus medinensis</i>	Bollus lesion rupture/ulcerate after contact ē water... Nodules/ulcer at lower extremity,(worm move from intestine to skin)	Treatment Remove worm. Wound care Metronidazole	 

Superf. Fungal Infect.	Dermatophytic Infections-dermatophytosis			
Classified according to body surface they infect (not acc. to species, due to same ttt. For All:- T. Capitis T. faciei T. Corporis T. cruris T. ungum, T. pedis T. manum,	Etiology & MOT & PF Trichophyton epidermophyton, microsporum is most common causes. Only on dead tissue of skin & its appendage. Can't survive on m.m MOT:- anthropophilic/zoophilic /geographic (soil, room floor) PF:- Moist condition, Common bath use, immunosuppres., Cushing, Atopy, Athlete's (skin tear), genetic predisposition	Classic Lesion:- well defined erythematous plaque*/patch with central clearing and advancing red scaly elevated sharply margined edge. may vesicles, pustules /follicular papules on border of lesion. (=active) site accord. To pt. Age- child → scalp, young older adult → inter-triginous onychomycosis → ↑ age	Diagnosis & DD. • Visualiz. Under M/S branching hyphae in keratinized material. • Sabouraud's agar culture • Wood light:- Microsporum spp. → Greenish	Prevention Treatment:- All species same ttt. (depend on site):- Topical may effective in dermatophytoses of skin but not for infect. of hair or nails. (applied bid to involved area optimally for 4 weeks including at least 1 week after lesions cleared. Apply at least 3 cm beyond advancing margin of lesion.) Imidazoles: Ketoconazole (Nizoral), Miconazole (Micatin), Clotrimazole • Terbinafine (Lamisil) Systemic:- Usually required for tinea capitis and tinea unguium. Also may required for inflammatory tinea and hyperkeratotic moccasin-type tinea pedis.
1-Tinea Capitis: MC dermatophytes in child. Charact. By irregular or well demarcated alopecia and scaling. It has 4 types:-				
A- Black dots type	Cause:- T. violaceum	Single /multiple patches, of short broken hair on scaly base Swollen hair shaft.	DD. Alopecia areata (normal skin) Seb- / Atopic derm- Chronic cut. LE Psoriasis • Lichen simplex chronicum	Topical not effective & need systemic for penetration of hair follicle Grisofulvin (only FDA approv.) 12.5mg/kg in 8wks -keroin, favus or in 4-6wks in blackdot, scally type. (@ max. Dose 6tab (tab=150mg) @contra in pregnant, haptic failure, photosensitivity) may Terbinafin, fluconazoles/itra for 2wks. Topical th:- Adjunctive Selenium sulfide/ketoconazole/povidone iodine lotion/shampoo—decrease viable fungi shedding.
B- scally type	M. Canis T.	As black dots but More scales, more circumscribed		
C-Favus type T. schoenleinii	Diffuse/entire scalp. Thick sulfur yellow adherent (bad fetid odor) concave (cup shape) crust= scutula. Around loose atrophy glossy paper white patch. Matting of adjacent hair & area of cicatricial Alopecia		DD. Impetigo Ecthyma Crusted scabies	
D- Kerion	Single usually but may multiple (Painful) Boggy nodules that drain pus from multiple opening, hair painless pulled (not break). Lead to cicat. Alopecia esp if opened. Ass. & L. adenopathy Usually caused by zoophilic (T. verrucosum, T. mentagrophytes) or geophilic species.		Cellulitis, furuncle, carbuncle	
T. Barbae	Skin and coarse hair of beard area & mustache. Painless hair removal used as clue to differentiate T. barbae from bacterial infection. • red inflammatory papules (/plaque) or pustules, often with exudation and crusting. Usually zoophilic so common on farmerties women		DD. S. barbae (painful hair removal) Pseudofolliculitis Perioral derm- Candidal folliculitis	Oral antifungal & topical (as tinea capitis) For 1 Month at least Continued at least 2-3wk after resolution of skin lesion.
2- Tinea corporis (T. circinate I)	Single/multiple annular scaly lesions with central clearing, a slightly elevated redened and sharp margination, that <u>maybe</u> absent when corticosteroid is used. Trunk, limbs, extremities, face (any glabrous skin except palm, sole, groin) Itching is variable Border may contain pustules or follicular papules		Dx. Clinical+ KOH exam. DD. Circinate impetigo Proseia Eczema psoriasis palba seborr/atopic allergic C. D.	Only topical antifungal cream no need for systemic unless widespread infection measures to decrease excessive skin moisture be careful. some dr. Dx T. corporis as eczema and give strong steroid → T. incognito??
T. facialis=faciel More common in children	Non bearded area of face (coarse haired area) Round annular red patches ... (Red area may indistinct and lesion may have little or non scaling or raised edge) Burning /itching worse & sun exposure T. incognito develop if steroid used. Because subtle appearance, it's known as T. incognito??		seborr/contact D. Lupus erythematosus Phototoxic drug eruption	Topical as tinea corporis

T. Cruris Jock Itch Some pt. Pruritis	Occur when ambient temp. & humidity high Occlusion from tight-fitting cloths Male > female Adult. Frequently ass. ē T. Pedis	Upper medial side of thigh(groin) may extend to buttocks ,abdomen. Scrotum, penis tend to be spared Erythematous patch e raised edge	DD. Erythrasma Candidiasis Intertrigo Eczema Intertrigenous psorias.	▪Topical antifungal ▪Adjunctive ttt. Low dose mild steroid—in first few days. For itching. ▪Rarely, Systemic ttt. Is needed Unless if superinfection ē candidal infection /if moist macerated area ▪Patient education on avoid moisturing.		
T. Ungulum (onychomycosis)	Ringworm infection of the Nails Subset of onychomycosis(Risk factors:- (Aging ,DM , poorly fitting shoes , tenia pedis) Note- Onychomycosis can caused by yeast,non dermatophytes molds) And account for 40% of nail dystrophy.		Dx. Must confirmed by KOH/culture befor Initiation of treatment. DD. Psoriasis ,L.palpus ,atopic dermatitis	Requir expensive,prolonged therapy (Grisofulvin/fluconazole/Itraconazole/Terbinafine) For 2-3months in fingernail infections. For 4-6months in toenails infections. Topical low efficacy Dr. Now use - long pulse wave Indiage laser (good result)		
T.manum (frequent. Asymptomatic Pruritis/Pain if fissured)	Often occure In pt. ē tenia pedis. Ringworm Infection of One-both hands.(mostly dominated) Palmar surface is diffusely dry &hyperkeratotic(more on creases) When fingernails are involved,vesicle & scant scaling may present so it resemble dyshydrotic eczema(dyshydrotic type of T.manum)	Atopic dermatitis, lichen simplex chronicus, allergic/ irritant CD, psoriasis vulgaris		Topical antifungal And emollient containing lactic acid(impossible to ttt. By topical due to thick skin in palmar S.corneum ,esp if ass. ē T.ungulum) Systemic itra 200mg 7d ,fluconazol 150mg 2 -4wk Relapse common if t. Pedis/onychomycosis not treated		
T.pedis Athlet's foot. (Φpredispose to bact. Infection , ,cellulitis ,lymphangitis) Usually asymptomatic Pruritus/Pain in bacterial superinfect.	A- Interdigital form- most common form. Ch. By fissuring maceration & scaling in intertriginous space between 4th & 5th toes . B- Moccasin-like distribution Plantar skin becomes chronically scaly and thickend & hyperkeratosis ,erythemia of sole,heel,side of feet. C- Vesiculobollus form- vesicles pustules and sometimes bulla in inflammatory pattern. on Sole, instep, webspaces.	DD. INTERDIGITAL .Erythrasma,impetigo,Candida intertrigo). Moccasin Type- Psoriasis ,eczematous dermatitis (dyshidrotic, atopicallergic contact) vesiculoBullous⇒ Bullous impetigo,allergic CD, dyshidrotic eczema,bullous d.		Topical antifungal cream to webspaces and other infected area Systemic therapy for refractory infection When marked Inflammation and vesicle formation occur and signs of early cellulitis present ⇒Add Topical antibiotics with strept. Coverage. Fungal nail infection should be treated to prevent relapse. prevention(daily washing ,benzoyl peroxide /antifungal powder)		
						
T. capitis black dots	T. Capitis scally type	T. Capitis Favus	T. capitis kerion	T. barbea	T. Faceie	
						
T. Corporis	T. Cruris	T. Manum	T. ungum	T.pedis interdigitalis	T.pedis Moccasin type	T.pedis bollus type

Candidiasis			
Def & Etiology	Clinical types:-	Diagnosis & DD.	Treatment
Infection of skin, usually of moist occluded Intertriginous areas and mucous membrane. Caused by yeast of genous candida Mostly by Calbicans (ubiquitous, saprophytic yeast, become pathogenic in favorable conditions).	A- Intertriginous infection (most common type) Well demarcated, erythematous, sometime itchy exudative patches of varying size & shape Usually rimmed by small stellated red based papules and pustules Occur in intertriginous areas as axilla, inflammatory areas, umbilicus, groin, gluteal fold, between toes (between 3rd & 4th finger of hand, not 4th/5th finger in feet), perianal candidiasis produces white, macerated pruritis ani	Yeast / pseudohyphae in Gram stain specimen / in KOH mounts of scraping from lesion Culture of no value (Candida is a normal colonizer of human body).	Avoid humidity Topical antifungal (keto/mef. Conazole) (effective) If pruritis—add low-potency topical steroid Systemic— Itraconazole for more severe cases.
	B- Candidal paronychia Begin around nails as painful swelling which then develops pus May from Improper performed manicures, common in kitchen worker, and whose hands are continuously in water. Subungal infections are characterized by distal separation of one/more nails (onycholysis) with white /yellow discoloration of subungal area.		
	C- Oral candidiasis		
	D- Genital candidiasis		



Intertriginous Cand.	Diaper candidiasis	Oral cand. thrush	Oral cand. Thrush	Cand. Glossitis/angular stomatitis	Cand. Vulvitis	Cand. balanoposthitis
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Mycetoma, Madura foot, maduromycetoma (type of deep fungal infection)					
Is a local, chronic, slowly progressive infection with various species of fungi or Actinomycetes, resulting in severe damage to skin, subcutaneous tissues and bones (most commonly of the feet and hands) Granules of various form and color are produced with abscesses and discharged to the surface through draining sinuses.	May be caused by : 1- (eumycetoma) (caused by true fungi) Incubation period up to 20 y- Eg- Mudurella mycetoma (black grains) 2- Aerobic actinomycetes (actinomycetoma) Incubation period up to 5 years eg- Nocardia brasiliensis (white grains or no color) Actinomadura madurae (yellow grains)	Transmission Cutaneous inoculation (thorn prick, wood splinter, stone cut) of organism, commonly with soil or plant debris into foot or hand. Epidemiology About 90% of patients are male bet 20 -50 years, Agricultural workers and laborers exposed to soil in tropical and subtropical regions. Most commonly seen in: India, Mexico, Nigeria, Somalia, Yemen, Sudan... Risk factors: poor hygiene, walking barefoot, necrotic injured tissue, poor nutrition.	Clinical features: History : lesion occurs at inoculation site weeks to years after, symptoms relatively few with little pain tenderness / fever. 2- cutaneous examination : Commonly seen on the foot and lower leg, firm painless nodules and development of further nodules produce irregular lumpy appearance with discharging pus containing grains 3- General examination : Fever if secondary bacterial infection.	Diagnosis 1- History and clinical examination 2- Direct KOH of pus 3- Culture on Sabouraud's agar 4- Dermatopathology 5- X-ray imaging of bone (osteolytic lesions) Differential diagnosis: - Chronic osteomyelitis - In elephantiasis there are no sinus tract. Treatment A- smaller lesions are best cured by simple excision. B- In other cases, medical treatment : - Eumycetoma (itraconazole - ketoconazole) - Actinomycetes (dapson - streptomycin - rifampin) C- Radical surgery usually amputation	
EuMycetoma	White grains	Actinomycetoma			

